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Protect, Prevent, Live Well

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The National Preparedness Report: Assessing the State of Preparedness
House Committee on Homeland Security
Subcommittee on Emergency Preparedness, Response and Communications
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Chairman Bilirakis, Ranking Member Richardson and members of the Subcommittee, my name is Dr. Georges Benjamin and I am the executive director of the American Public Health Association (APHA). Founded in 1872, APHA is the oldest, largest and most diverse organization of public health professionals in the world. The association aims to protect all Americans and their communities from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. APHA represents a broad array of health providers, educators, environmentalists, policy-makers and health officials at all levels working both within and outside governmental organizations and educational institutions. I appreciate the opportunity to appear before you today to discuss the state of public health emergency preparedness and thank you for your leadership on this important topic.

The nation's public health system has a long and proud history of providing services during public health emergencies by providing a range of services from acute infectious disease detection, post disaster environmental risk assessment and long term surveillance for emerging post disaster threats to health. The public health system then works to make us safer by preventing or mitigating these risks to health using a variety of clinical and nonclinical interventions. For many years we as a nation had underinvested in public health system emergency preparedness, however, since the terrorist attacks on September 11, 2001and the subsequent anthrax attacks later that year, significant investments in public health preparedness and response have occurred. There is no question that these investments have greatly improved the nation's overall ability to prevent, respond to and recover from public health emergencies including bioterrorism, chemical incidents, radiological and nuclear events, infectious disease outbreaks and natural disasters. However, we still have a long way to go to achieve a level of optimal preparedness. In fact, we have had significant regression in the infrastructure needed to achieve this desired level.

The Federal Emergency Management Agency's 2012 National Preparedness Report highlights many of the improvements we have seen since 2001 across a wide range of preparedness activities and highlights several areas where we have made enormous progress. I believe the report authors should be commended for the areas where they have focused most intently. There

is one area of the report however, that does require more detail to give the committee a fuller understanding of the nation's level of public health and medical preparedness. That area is found on page 47 where a key finding of the reports notes *"The Nation has built a highly respected public health capability for managing incidents, but recent reductions in public health funding and personnel have impacted these capabilities."* I would like to give a more complete explanation about the impact that current funding and workforce reductions have on the ability of the public health system to respond not only to public health emergencies, but also to undertake the day-to-day responsibilities that keep our communities safe and healthy.

The state of public health preparedness

There are core functional capacities you want in a public health preparedness system. You want to know when a disease syndrome first enters a community, the ability to rapidly identify the cause of the disease and how it is contracted, the ability to conduct accurate new case findings and tracking, the ability to communicate effectively to a range of stakeholders (including the public) and disease containment and treatment ability. In a terror attack the forensic component of these efforts magnify the importance of these requirements. Over the past several years we have had significant erosion in our core capacity to do many of these things. Let me start by putting it in perspective and relate the critical role federal programs and funding play in state and local public health emergency preparedness and response activities.

During the anthrax attacks in October 2001, I was the secretary of health for the State of Maryland. Baltimore City and all 23 of Maryland's counties responded in order to treat people who had been exposed through the U.S. postal system or in the Hart Senate Office Building and to address, statewide, white powder reports which paralyzed the nation. This experience taught me several important lessons:

- **A good plan is an essential first step:** Fortunately for Maryland, we had previously developed a public health preparedness plan and had some early capacity because of my interest in preparedness (I am an emergency physician) and more importantly, a small grant from the US Centers for Disease Control and Prevention (CDC). We also learned how important it is to actually exercise the plan because it had been untested and many lessons were learned from actually having to use it.
- **Disease response does not recognize borders:** The index case in the Washington, DC area was a Maryland resident who was exposed in Washington, DC and hospitalized in Virginia. Only the federal government can build a regional capacity to address this kind of disease exposure. No single jurisdiction could have handled this alone. A robust surveillance system, sustained training and local, state and federal cooperation is required for an adequate response.
- **Delivering countermeasures is complex:** The Maryland plan anticipated the need to get pharmaceuticals in large amounts quickly and recognized the turnaround time to get the contents of the strategic national stockpile (SNS) was longer than we could wait. We had a short term plan to utilize the pharmacy system from our mental health system for pharmaceuticals (Cipro) until the SNS was available. This temporary system worked but we recognized the benefits of the SNS as soon as it became available because of the prolonged nature of the nationwide response to the anthrax letters. We designed an on-

the-spot distribution system and when the SNS supply arrived we distributed it to local health departments all over the state during the night. If the SNS did not exist or if we had not owned our own hospitals we would not have had any meaningful capacity to respond. Those exposed would have had anthrax in their systems for much longer periods of time and we may have had many other serious cases.

- **Communication is a big deal:** Anthrax is a rare disease to the general practicing medical community. Over days and weeks our call center was swamped with calls from health professionals looking for current diagnostic and therapeutic information about anthrax. We also had numerous calls from the general public and the media seeking reliable information. Our ability to utilize a range of communication tools from automated telephone responses, our web page, press releases, news conferences and live call takers was essential to keeping the people informed and calm. The newly instituted Health Alert Network was an important enterprise-wide communication tool that provided reliable public health information in a timely way on a regular basis. These efforts were coordinated with a range of state, local and federal agencies. In those days every health department in America did not have ready access to email as we do today. Clearly our national capacity to respond is more effective when we have a system that can leverage all of the available components.
- **Preparedness is everyone's secondary job for surge capacity:** Our disease surveillance staffs were superb but we were often challenged to keep up with our day-to-day responsibilities before the attacks. When the attacks occurred, we utilized many other staff from across the agencies that were in programs unrelated to public health preparedness to use their skills in support of this emergency response. In this way, chronic disease epidemiologists, maternal child health epidemiologists and HIV/AIDS workers were recruited to help. Often working 18 to 20 hours a day, sleeping on the floor or on cots in their offices these heroic public servants did what was required to respond to this effort. Erosion in other programs unrelated to preparedness has a negative impact on the ability of a public health agency to scale up when a disaster occurs.
- **A robust national public health laboratory network is essential:** Maryland is fortunate to have had one of the best public health laboratories in the country. A public health laboratory is very different from a hospital or clinical laboratory. We served as the reference lab for many lab samples, the prime testing lab for many clinical and nonclinical samples and the link to the FBI for forensic samples. Our laboratory was swamped with samples from sources all over Maryland and the District (as their laboratory did not have appropriate equipment to do the testing at the time). Over 300 samples a day came into the lab for several weeks. All of the positive samples required follow up with the sender and had to follow a chain of custody to be sent to the FBI. This relatively limited and small, but serious incident (five letters), completely inundated our system. It was a massive undertaking for months and a staffing and logistical challenge. The federally supported laboratory response network played a critical role in our response activities.
- **We were lucky:** Five letters resulted in a nationwide event with 17 cases of illness, five deaths, more than 33,000 people being placed on antibiotics and thousands of emergency responses because of the fear that any white powder discovered could be anthrax. In Maryland, an additional naturally occurring outbreak such as a food-borne outbreak at a

restaurant, a wedding or a second terror attack with another agent would have been impossible to manage effectively with our existing state infrastructure at the time.

I have followed the progress of Maryland's efforts since I left in December 2002 and have been generally pleased that the state and the agency have continued to improve on their preparedness system and have effectively switched to an all hazards approach, as has most of the nation. Yet, I remain concerned about erosion in capacity of the system when I see what is happening in places like Washington State where an outbreak of pertussis continues to grow and response capacity is hampered by the deterioration of the local public health infrastructure in particular.

The State of Washington began experiencing an outbreak of pertussis about 21 weeks ago. Pertussis is a disease commonly found in childhood that has been greatly eliminated because of a safe and effective vaccine given during childhood. As of May 26, 2012 there have been 1,947 reported cases, 127 under the age of one with 30 of them hospitalized. As of this reporting there have not been any deaths. This is compared to 154 reported cases during the same time period in 2011. The outbreak continues to grow. While the exact causes of the outbreak are unclear, it may be related to children not getting their full series of vaccinations and waning protection in the previous vaccine due to changes in the vaccine formulation.

Responding to this outbreak is believed to be hampered by staffing shortages in some parts of the state (as reported in the New York Times on May 12, 2012 and in my personal communications with the Washington State Health Officer). My concern is that this is a superb state health department with solid leadership that has to contend with dwindling resources particularly at the local level. According to reports mentioned above, local health departments in Washington have experienced reductions in funding due to the recession, resulting in diminished staffing levels, and as a consequence, affected their ability to respond in a more effective manner. I am very concerned that this represents a microcosm of what is awaiting the rest of the nation as our infrastructure further dwindles. If we cannot address a large but classic outbreak I have real concerns about our ability to respond effectively to a novel or an intentional one.

Our nation's public health laboratories are also facing serious challenges due to funding and staffing reductions. According to surveys conducted by the Association of Public Health Laboratories, which represents laboratories with a public health mission, many public health laboratories have also lost staff and have had to curtail other important programs in order to maintain preparedness capabilities. The State Public Health Laboratory in California, for instance, had to eliminate a training program intended to produce laboratory workforce leadership in order to maintain adequate preparedness funding. In New Jersey, the number of scientists certified to work on select agents (testing on biothreat materials, like anthrax) has been reduced from 15 down to five, threatening the state's laboratory surge capacity in the event of a public health emergency or disease outbreak. Massachusetts has also been forced to reduce other areas of funding in order to maintain its preparedness activities, including reductions in laboratory oversight management and quality assurance.

As a nation we are facing two major challenges that this committee should be aware of as you assess the state of public health emergency preparedness in America: the public health workforce crisis and worsening fiscal support.

An eroding public health workforce

Our state and local health departments continue to struggle with significant job losses and painful budget cuts. Unfortunately, state and local budgets have not recovered from the recession. Since 2008, more than 52,000 public health jobs have been lost at local health departments and state and regional health agencies. These numbers represent 17 percent of the state and territorial public health workforce and 22 percent of the local public health workforce.

State and territorial health agencies continue to report ongoing job losses and budget cuts to critical public health programs. According to the most recent survey of state health agencies conducted in March 2012 by the Association of State and Territorial Health Officials, between July 1 and December 31, 2011, 30 percent reported staff layoffs, 41 percent reported the loss of staff through attrition, 24 percent reported cutting entire programs and 46 percent reported a reduction in services provided. Cumulatively, since 2008, the numbers are even greater with 56 percent reporting layoffs, 62 percent cutting entire programs and 91 percent reporting a reduction in services provided.

The situation is just as dire among local health departments. According to a January 2012 survey of local health departments conducted by the National Association of County and City Health Officials, 57 percent of local health departments reduced or eliminated at least one public health program in 2011, with emergency preparedness activities taking the biggest hit. Twenty three percent of local health departments reported cuts to emergency preparedness programs in 2011. The effects of the recession continue to be felt among local health departments with 41 percent of departments reporting that their current year's budget is less than the previous year and 41 percent reporting that they expect additional cuts in the coming fiscal year.

A pattern of destructive cyclic funding for public health

Funding for public health programs has a history of "yo-yo-funding." That is, funding continues until we get improvements in capacity and improved health outcomes, then the funding cycles downward only to find the problem return often at an increased overall cost. This happens at the federal, state and local level. An unreliable, insufficient and unsustainable funding pattern erodes system preparedness for all hazards and threats and leaves our nation at risk.

Like many domestic programs critical federal dollars that fund many of the public health emergency preparedness activities that fall to our state and local health departments continue to decline. According to the report *Ready or Not? Protecting the Public from Diseases, Disasters, and Bioterrorism* issued by Trust for America's Health in December 2011, from 2005 to 2012, federal funding for state and local preparedness activities has been reduced by more than 38 percent (when adjusted for inflation).

CDC's Public Health Emergency Preparedness (PHEP) program is the foundation and bedrock of public health preparedness in the U.S. The program provides critical resources, scientific expertise and coordination to ensure that our state and local health departments are prepared to respond to an emergency and to ensure that all Americans will be protected. Unfortunately, funding for this critical program has decreased significantly over the past several years.

Reductions to this funding will certainly limit the ability of our health departments to monitor, assess and respond to public health threats in their communities. These cuts could impact the capacity of disease surveillance staff to detect an outbreak or a bioterrorist attack, which would limit the ability of state laboratories to quickly respond to the surges in testing that would be needed, and hamper the ability of state and local health authorities to respond adequately in order to protect the public from exposure or ensure the rapid distribution of life-saving medicine and medical supplies. Unfortunately, the president's budget request would reduce support for state and local preparedness by an additional $8 million in FY 2013.

Funding for the Strategic National Stockpile is also at risk. As noted earlier the SNS is an essential component of the nation's ability to ensure an adequate supply of critical medicine and equipment to aid state and local public health agencies are armed with the tools they need to respond to a national health emergency. Experience has shown how valuable the SNS supplies of antibiotics, chemical antidotes and other life-saving medicines and equipment are when local supplies become depleted during an emergency. CDC's ability to maintain the SNS and state and local government's ability to implement the distribution are dependent on a well funded, agile and reliable system. In addition to supplies, it is the strategically coordinated distribution plans that federal, state and local government have designed and are required to exercise regularly that will impact how quickly and thoroughly these supplies are distributed. Sustained funding is essential to maintain a sense of readiness for this capacity.

Unfortunately, funding for the SNS was reduced by $57 million in FY 2012 and the president's FY 2013 budget request proposes cutting this critical funding by an additional $48 million in FY 2013. By cutting this funding, we jeopardize efforts to develop initiatives to reduce distribution response times. Reductions in this funding also put the nation at risk of being unprepared and unable to provide needed medication to all persons affected by a public health emergency. The SNS supply must be replenished when the shelf life of the medications expire. Additionally, the facilities maintained and staff involved in the production of the medical countermeasures must be in place to appropriately respond to the changing needs of the stockpile. Speed, sufficient supplies and staff who know and have practiced using the plans are all essential to a rapid response and recovery.

Another key federal program that provides needed resources to state and local health departments to prepare and respond to all hazards is the Hospital Preparedness Program (HPP) administered by the HHS Office of the Assistant Secretary for Preparedness and Response. Funding provided through this critical program enhances and improves overall medical surge capacity at hospitals and other key components of the healthcare system in a public health emergency. We have seen the value of this program very recently in Joplin, Missouri. After the tornadoes devastated that city last year, roughly 30 percent of the City of Joplin's infrastructure was destroyed including St. John's Regional Medical Center, which had to evacuate all 183 patients from the facility. Equipment funded through the HPP assisted staff in evacuating patients down as many as eight flights of stairs and a fully operational 60-bed mobile medical unit was deployed and fully operational within a week of the tornado. This program, unfortunately, is also at risk. The president's FY 2013 budget request proposes to reduce funding for HPP by $142 million or 36 percent.

In addition to reductions in funding for state and local preparedness and response capabilities, we are also concerned with the declining funds for CDC's preparedness and response activities. While the president's budget request provides a small $9 million increase for FY 2013, funding for CDC's internal capacity has declined by nearly 50 percent since FY 2006. With this funding, CDC operates its Emergency Operations Center around the clock and serves a critical role providing rapid logistical support to deploy personnel and transfer supplies and equipment to support state and local authorities on the front lines during public health emergencies. The center also plays a central role in activating response operations, deploying personnel to disaster zones and investigating health security threats. Continued underfunding of CDC's preparedness and response activities will undermine the agency's ability to coordinate communications and response activities and to provide scientific, logistical and personnel support to state and local responders.

APHA is also very concerned about the additional blow that the pending sequestration would have on funding for public health programs broadly. As you know, the Budget Control Act created a process known as sequestration to encourage the so-called "supercommittee" to come up with a viable deficit reduction proposal. Because the supercommittee failed to reach agreement on a plan, sequestration, or across-the-board cuts to discretionary funding estimated in the range of 8-10 percent, is scheduled to take place in January 2013. Cuts of an additional 8-10 percent on top of the recent cuts to federal preparedness programs would be nothing short of devastating. Cuts of this magnitude could eliminate funding for the 10 national Level 1 chemical labs, shut down CDC's emergency operations center and further reduce funding for SNS and other state and local preparedness funding.

Conclusion

Public health has historically been asked to do more with less. It is now at a breaking point. Unless we start supporting our public health system in a more sustained way, our capacity will continue to erode and our ability to respond quickly and competently will evaporate. Funding public health emergencies once the disaster has already occurred is not an effective way to ensure either preparedness or accountability.

We must have a robust public health system with adequate levels of personnel who are well trained and properly equipped to address a variety of public health threats. Additionally, the ability to generate immediate surge capacity by using an "all hands on deck" and "whole of community" approach is essential and requires a better recognition of the role other components of the public health system plays in preparedness. Funding is tight at all levels of government but as the economy recovers and we begin to make new strategic investments in homeland defense, Congress must make funding the public health system a top priority. Protecting the public's health is a matter of national security.

Time and again, we have failed to think more strategically about the future of our nation's public health system, to develop a blueprint for where we want to be in the future and how best to fund it. APHA believes that far more significant sustained investments in public health need to occur if we are to prepare the nation's public health system to protect us from the leading causes of

death, and prepare us for a rapid response to a range of public health emergencies, whether naturally occurring or the result of a chemical, biological, radiological, or nuclear attack.

Thank you for the opportunity to testify before you today about state of the nation's preparedness and our ability to deal with public health emergencies. On behalf of the American Public Health Association, I look forward to working with you to strengthen all aspects of our nation's public health infrastructure to ensure the health and safety of the American public. I am happy to answer any questions you may have.